

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
'may' retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Information from birth cert.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. MARYLAND b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESTON		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. STREET ADDRESS same Federalburg R.F.D. #2 Box 84	
3. NAME OF DECEASED (Type or print) Darrell Duwayne Bailey		4. DATE OF DEATH May 27 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25 1961
9. AGE (In years last birthday) infant		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Retallick		14. MOTHER'S MAIDEN NAME Barbara A. Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Dany Bailey		Address Federalburg	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage of 771.5 DUE TO the new born Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that death occurred at 5:40 PM, from the causes and on the date stated above.			
22a. SIGNATURE E. C. H. Schmidt M.D.		22b. DATE 28 May 1961 SIGNED	
22c. PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22d. ADDRESS Eston, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 29		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery		23d. LOCATION (City, town, or county) (State) Federalburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams		25a. REC'D BY REGISTRAR MAY 31 '61	
ADDRESS Federalburg Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DEATH

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11-11-15

CERTIFICATE OF DEATH

11-11-15

(M)

X

X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6062

06048

1. PLACE OF DEATH a. COUNTY <i>Tacket</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Tacket</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural League</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Richard</i> Middle <i>Kemp</i> Last <i>Bryan</i>				4. DATE OF DEATH Month <i>May</i> Day <i>21</i> Year <i>1961</i>			
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>May 10, 1892</i>		9. AGE (In years last birthday) <i>69</i> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truckee & Farming Owner & Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Adam Bryan</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Bryan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-32-7306</i>		17. INFORMANT Name <i>James Bryan</i> Address <i>Trappe, Md. R.D.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331x Cerebral Hemorrhage, left.</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <i>E. C. H. Schmidt</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>27 May 1961</i>			
22c. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>		22d. ADDRESS <i>Easton, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 23, 61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City, town, or County) (State) <i>Easton Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Richard M. ...</i>				25a. REC'D BY REGISTRAR DATE <i>MAY 25 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>	

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MAINTAINING ARE SPECIMENS OF HEALTH

NATIONAL BUREAU OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF DEATH

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CHIEF OF BUREAU

DEPARTMENT OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20492

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06051

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1 702 South Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>girl</u> Last <u>Callahan</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1961</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY AT BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Joseph F. Callahan</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH ANN HUDSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Dr. Joseph Callahan</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cyathoblastosis Fetalis</u> 773-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Nyaline memb. disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-30-61</u> to <u>5-1-61</u> that (I) (we) last saw the deceased alive on <u>5-1-61</u> and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Donald F. Bartley</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>5-3-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald F. Bartley</u> M.D.		22d. ADDRESS <u>EASTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 3, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Landing Rock Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Easton (Rural) Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Neumann - Son</u>		ADDRESS <u>Easton, Md.</u>	
25a. REC'D BY REGISTRAR <u>DATE MAY 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

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CERTIFICATE OF DEATH

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VR A15 (4)
15M 9/59

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6065
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06053

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp</u>		d. STREET ADDRESS <u>400 Needwood Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>LEE</u> Last <u>Dunlap</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1906</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Storm Doors</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Dunlap</u>		14. MOTHER'S MAIDEN NAME <u>ukn.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>267 28 8907</u>	
17. INFORMANT <u>John L. Dunlap, II, Easton, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypopharyngeal carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>147X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>17 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> <u>1960</u> to <u>5-28</u> <u>1961</u> , that (I) (we) lost <u>saw the deceased alive on 5-28</u> <u>1961</u> , and that death occurred on <u>10:20</u> <u>PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>5/31/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMT.</u>		23d. LOCATION (City, town, or county) (State) <u>BLADENBURG, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Gual</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 31 '61</u>	
ADDRESS <u>EASTON, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CELEBRATE DECEMBER 12TH
 WITH A SPECIAL OFFER
 FROM THE STATE OF TEXAS

1000

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VR A15 (4)
ISM 9/59

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6066

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06054

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON. c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY TALBOT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St Michaels. d. STREET ADDRESS Cherry St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maryann Middle Emack Last Essig		4. DATE OF DEATH Month 5 Day 12 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 3 1885
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Phoenixville Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ed Franklin D. Emack, M.D.		14. MOTHER'S MAIDEN NAME Clara L. Lowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT J. Beresford Emack, Stanford, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiac Hypertrophy DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Constrictive Heart Failure & Coronary Artery Disease		INTERVAL BETWEEN ONSET AND DEATH 24 Hrs 5 years 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1 April 1961 to 12 May 1961 , that (I) (we) last saw the deceased alive on 12 May 1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE R. Haulerath		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-15-61	
23c. NAME OF CEMETERY OR CREMATORY West Laurel Hill		23d. LOCATION (City, town or county) (State) Baldwinsville, Pa	
24. FUNERAL DIRECTOR'S SIGNATURE L. S. Hamketon, Harrison, Md		25a. REC'D BY REGISTRAR MAY 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Huns			

CERTIFICATE OF DEATH

Reg. Dist. No. 06055

6067

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home		d. STREET ADDRESS Chester	
3. NAME OF DECEASED (Type or print) Daisy L. Golt		4. DATE OF DEATH Month May Day 24 Year 1961	
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1-1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Jones		14. MOTHER'S MAIDEN NAME Mary Ellen McCullah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT George Golt--Chester, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular thrombosis DUE TO atherosclerotic cerebrovas d. DUE TO chronic cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. INTERVAL BETWEEN ONSET AND DEATH 5 day			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-1-61 to 5-24-61 , that I last saw the deceased alive on 5-24 , 19 61 , and that death occurred at 1:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) St Michaels Md DATE SIGNED 5-25-61 ACTUAL SIGNATURE Theresa Greer PHYSICIAN'S NAME (Type) Wm M Reeser Jr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 26	22c. NAME OF CEMETERY OR CREMATORY Stevensville	22d. LOCATION (City, town, or county) (State) Stevensville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar H. Lane		24a. REC'D BY REGISTRAR DATE MAY 29 '61	
ADDRESS Church Hill, Md.		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAKING STATEMENT OF WORKS DONE TO
CENTRALITY OF DEATH
[Illegible text follows, appearing as bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY Talbot						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton					
c. LENGTH OF STAY IN 1b 4 da.						d. STREET ADDRESS 1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Daniel Gribbons						4. DATE OF DEATH May 13 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/8/1910?		9. AGE (In years last birthday) 50? yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) worked in saw mill				10b. KIND OF BUSINESS OR INDUSTRY saw mill				11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Gribbons						14. MOTHER'S MAIDEN NAME Grace Fleacher					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 579.2 DUE TO mesenteric thrombosis Conditions, if any, which gave rise to immediate cause (b) 44 days (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH (e), stating the underlying cause last.										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Louis M. Kelly						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) WELTY						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/17/61		22c. NAME OF CEMETERY OR CREMATORY Anatomy Board H. of Md.		22d. LOCATION (City, town, or country) 29 S. Green St. Baltimore		(State) Md.			
23. FUNERAL DIRECTOR Ambleton Funeral, St. Michaels, Md.						24a. REC'D BY REGISTRAR DA MAY 19 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

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1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-St. Michaels		c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Philip Willey Harrison		First Middle Last		4. DATE OF DEATH May 23 19 61		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1864	
9. AGE (in years last birthday) 96 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret.-ice cream		10b. KIND OF BUSINESS OR INDUSTRY manufactor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Harrison				14. MOTHER'S MAIDEN NAME Mary Wiley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT 14245 Glastonbury Mrs. Harold Bush, Detroit, Michigan			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 600.0 DUE TO Acute Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral and Generalized Contractures							INTERVAL BETWEEN ONSET AND DEATH 30 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 May 19 61 to 23 May 19 61 , that (I) (we) last saw the deceased alive on 22 May 19 61 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE R. Lane Wroth				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-24-61	
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth, M.D.				22d. ADDRESS St. Michaels, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/61		23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Michaels, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Hamilton Conell				ADDRESS St. Michaels, Md		25a. REC'D BY REGISTRAR MAY 31 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6070

Item 8 Film G288

6/6/61 1wk

06058

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 1 515 So. Washington St.	
3. NAME OF DECEASED (Type or print) First George Middle Evans Last Holmes		4. DATE OF DEATH Month May Day 26 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1902 Aug. 14, 1912
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comptroller		10b. KIND OF BUSINESS OR INDUSTRY Finance Corp.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Sanders Holmes		14. MOTHER'S MAIDEN NAME Dolly Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. ukn.	
17. INFORMANT Mrs. Ethel V. Holmes, Easton, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic coronary thrombosis DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Agitation		INTERVAL BETWEEN ONSET AND DEATH 16 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 16 May 1961 to 26 May 1961 , that (I) (we) last saw the deceased alive on 26 May 1961 , and that death occurred at 12 M. from the causes and on the date stated above.	
22a. SIGNATURE Thorston Harrison		22b. DATE SIGNED 26 May 61	
22c. PHYSICIAN'S NAME (Type) THORSTON HARRISON		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/30/61	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemt.	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE W. Traugott Carroll		25a. REC'D BY REGISTRAR EASTON, MD. DATE MAY 31 '61	
25b. REGISTRAR'S SIGNATURE Robert S. Haines			

TO HOPEFUL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

6071

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06059

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Audrey</u> Middle <u>Teresa</u> Last <u>Jenkins</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1941</u>	
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>None</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic meningitis</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if in this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>E. C. H. Schmidt</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>26 May 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/29/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trappe, Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Trappe Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Darnell</u>				ADDRESS <u>Easton Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 31 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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CERTIFICATE OF DEATH

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CHURCH OF THE
LIVING GOD

WOMEN'S
SOCIETY

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

6073

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06061

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b DOA 9PM		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 10 CHOPTANK AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wilson GALEN KEENE				4. DATE OF DEATH Month MAY Day 24 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 2, 1914	9. AGE (In years, months, days) 47 yrs.	IF UNDER 1 YEAR Months 47 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State of foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BERNARD KEENE		14. MOTHER'S MAIDEN NAME RUBY SHENTON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WWII 214-07-7167 - MRS. EVELYN KEENE, EASTON, MD			
16. SOCIAL SECURITY NO. 214-07-7167				17. INFORMANT Address 8 CHOPTANK AVE, EASTON, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE INJURIES DUE TO AUTO ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 823X (b) AUTO ACCIDENT DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) DRIVER OF CAR - LEFT ROAD + STRUCK TREE				INTERVAL BETWEEN ONSET AND DEATH MINUTES			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) DRIVER OF CAR - LEFT ROAD + STRUCK TREE					
20c. TIME OF INJURY Month, Day, Year Hour 5-24 1961		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ROUTE 50		20f. (City or town) (County) (State) W. TRAPPE TALBOT MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> end in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Louis D. Kelly				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) WIELTY				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 5-24-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/27/61		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		22d. LOCATION (City, town, or country) (State) Easton, R.D. Maryland	
23. FUNERAL DIRECTOR W. Langston Cowley				ADDRESS EASTON, MD.		24a. REC'D BY REGISTRAR MAY 31 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10410

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2078

NEW YORK
STATE

(M)

(1)

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Occupation", "Cause of Death", "Time of Death", "Place of Death", "Signature" are faintly visible.]

Signature of Medical Examiner, R. J. Harrison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

6072

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film G285 6/2/61 1wk

16060

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ira</i> Middle <i>Low</i> Last <i>Jones</i>		4. DATE OF DEATH Month <i>May</i> Day <i>27</i> Year <i>1961</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 9, 1871</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR: Months <i>0</i> Days <i>5</i> Hours <i>5</i> Min. <i>5</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWORK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWORK</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ESMA LOWE</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET RECORDS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>RECORDS - Home For Aged Women, Easton, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia, secondary</i> DUE TO <i>159X</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last, (b) <i>Gastric intestinal carcinoma, site</i> DUE TO <i>unknown</i> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH (?) (?)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>19 May</i> 19 <i>61</i> , to <i>27 May</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>27 May</i> 19 <i>61</i> , and that death occurred at <i>7:02 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Thurston Harrison</i>		22b. DATE <i>27 May 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>		22d. ADDRESS <i>Easton Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5/29/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>GREENSBORO CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>GREENSBORO, MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Thompson Carroll</i>		25a. REC'D BY REGISTRAR <i>EASTON, MD.</i>	
25b. REGISTRAR'S SIGNATURE <i>Anthony S. Knead</i>		DATE <i>MAY 31 '61</i>	

RECEIVED

CHIEF TOWN

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6074

06062

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MD b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN TB 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle LANE Last LANE				4. DATE OF DEATH Month 5 - Day 7 Year 1961			
5. SEX Male		6. COLOR OF RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 29, 1898	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 6 Days 22 Hours 15 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Talbot Co. Md				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William Lane				14. MOTHER'S MAIDEN NAME Bessie Lane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 217-03-2212			
				17. INFORMANT Naomi Willis Address Easton Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH acute
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/25 , 19 61 , to 5/7 , 19 61 , that (I) (we) last saw the deceased alive on 5/7 , 19 61 , and that death occurred at 7:35 AM, from the causes and on the date stated above.							
22a. SIGNATURE L. J. Eglseider M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 5/8/61			
22c. PHYSICIAN'S NAME (Type) L. J. Eglseider M.D.				22d. ADDRESS Easton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF May 10, 1961		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.		23d. LOCATION (City, town, or county) Easton Md (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Maureen Newman ADDRESS Easton Md				25a. REC'D BY REGISTRAR DATE MAY 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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6075
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06063

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>29</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp</u>				d. STREET ADDRESS <u>1 Wye Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>Mill</u> Last <u>McAinsh</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Leg. Sep.</u>		8. DATE OF BIRTH <u>April 23, 1914</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George McAinsh</u>				14. MOTHER'S MAIDEN NAME <u>Effie Mill Hunter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>013 05 2436</u>		17. INFORMANT <u>Mrs. Joseph D. Pierce, Mystic, Conn.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) <u>Myocardial Infarction acute</u> (45 minutes)		INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> (45 minutes)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1960</u> to <u>5/23, 1961</u> , that (I) (we) last saw the deceased alive on <u>5/23, 1961</u> , and that death occurred at <u>5:35 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>L. J. Eglseder</u>				22b. DATE SIGNED <u>May 31 '61</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. J. Eglseder</u>				22d. ADDRESS <u>Easton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Oxford, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Cunniff, Easton, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

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(M)

(I)

CHIEF CLERK

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CERTIFICATE OF DEATH

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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6076

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06064

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Dor ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON MEMORIAL Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sturlock	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 09X-2	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Jane Last MOORE		4. DATE OF DEATH Month MAY Day 1 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Moore		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Ms Estelle Toney, E. T. Market		Address E. T. Market	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 4-26-1961 to 5-1-1961 , that (I) (we) last saw the deceased alive on 5-1-1961 , and that death occurred at 5:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Arthur B. Cecil		22b. DATE SIGNED 5-2-61	
22c. PHYSICIAN'S NAME (Type) ARTHUR B. CECIL M.D.		22d. ADDRESS EASTON, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/4/61	
23c. NAME OF CEMETERY OR CREMATORY Salem		23d. LOCATION (City, town, or county) (State) Salem Md	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth S. Melling, East New Market		25a. REC'D BY REGISTRAR DATE MAY 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

6077

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06065

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>32 hr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON MEMORIAL Hosp</u>				d. STREET ADDRESS <u>0 9X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Clements</u> Last <u>Rhue</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/1894</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming own farm</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own</u>		11. BIRTHPLACE (State or foreign country) <u>D.S.D.</u>	
13. FATHER'S NAME <u>George M. Rhue</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth P. Rhue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Fred Rhue, Talbot, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>29 May 1961</u> to <u>30 May 1961</u> , that (I) (we) last saw the deceased alive on <u>31 May 1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thornton Harrison</u>				22b. DATE SIGNED <u>1 June 61</u>		22c. PHYSICIAN'S NAME (Type) <u>THORNTON HARRISON</u>	
22d. ADDRESS <u>Easton, Talbot, MD</u>				22e. REC'D BY REGISTRAR DATE <u>JUN 6 '61</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF <u>6/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		23d. LOCATION (City, town, or county) (State) <u>Talbot MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leith S. Kellogg</u>				25. ADDRESS <u>East new market</u>			

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06066

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORDOVA RD		c. LENGTH OF STAY IN lb 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		47 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 2ND & C ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SARAH F D RICHARDS				4. DATE OF DEATH Month Day Year MAY 28 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 12, 1876		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY MD		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLINTON DENNY				14. MOTHER'S MAIDEN NAME ELEANOR STANTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. JOHN R. WALSH,		Address CORDOVA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 CORONARY OCCLUSION DUE TO A-S HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Louis Welty				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-28-61	
EXAMINER'S NAME (Type) WELTY				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF May 31, 1961	22c. NAME OF CEMETERY OR CREMATORY Edgar Hill Cemetery		22d. LOCATION (City, town, or country) Washington DC		(State)	
23. FUNERAL DIRECTOR Allen Cook				ADDRESS Easton Md		24a. REC'D BY REGISTRAR MAY 31 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>1A160t</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY in lb <u>16 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial</u>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> d. STREET ADDRESS <u>River Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print) <u>James Leonard Robinson</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1961</u>				5. SEX <u>Male</u>				6. COLOR OR RACE <u>Negro</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>April 9, 1935</u>				9. AGE (In years, last birthday) <u>26</u> yrs. IF UNDER 1 YEAR: Months <u>05</u> Days <u>X-2</u> IF UNDER 24 HRS.: Hours <u>00</u> Min. <u>00</u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>								10b. KIND OF BUSINESS OR INDUSTRY <u>Draper's Food</u>								11. BIRTHPLACE (State or foreign country) <u>Georgia</u>								12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Eddie Robinson</u>												14. MOTHER'S MAIDEN NAME <u>Elizabeth Stevenson</u>																					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW II												16. SOCIAL SECURITY NO. <u>220-28-1375</u>								17. INFORMANT <u>Jeanette E. Robinson, Federalsburg, Md.</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> <u>823 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Internal Injuries</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto skidded and went off road</u>												INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs -</u>																					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto skidded and went off road</u>																									
20c. TIME OF INJURY Month, Day, Year Hour <u>11:45</u> a.m. <u>July 27</u> 19 <u>61</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 318</u>				20f. (City or town) <u>Rural Federalsburg</u>				20g. (County) <u>Caroline Md</u>				20h. (State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																	
ACTUAL SIGNATURE <u>Dawson O. George</u>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED <u>May 30, 1961</u>									
EXAMINER'S NAME (Type) <u>Dawson O. George, M.D.</u>												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								22b. DATE THEREOF <u>June 3, 1961</u>								22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>								22d. LOCATION (City, town, or country) (State) <u>Federalsburg, Maryland</u>									
23. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Maryland</u>												24a. REC'D BY REGISTRAR DATE <u>JUN 1 '61</u>												24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>									

100-100000
100-100000

(M)

(I)

000000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

State of New York
County of New York

City of New York

On this day of

1900

at New York

I, the undersigned

Medical Examiner

do hereby certify

that the within

is the body of

the deceased

person named

in the foregoing

certificate of death

and that the same

has been examined

and found to be

the body of the

6080

6068

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - ST. MICHAELS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ralsey Middle B Last Scotfield		4. DATE OF DEATH Month May Day 28 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 27, 1892
9. AGE (In years last birthday) 68 <input checked="" type="checkbox"/> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. WAREHOUSER		10b. KIND OF BUSINESS OR INDUSTRY STEEL	
11. BIRTHPLACE (State or foreign country) CONN.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM C. SCOTFIELD		14. MOTHER'S MAIDEN NAME CORDELIA M. KNAPP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. R.B. SCOTFIELD, JR.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acidosis DUE TO (c) Diabetes		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 55 to 19 55 , that (I) (we) lost saw the deceased alive on May 27, 1961 and that death occurred at 11 AM , from the causes and on the date stated above.			
22a. SIGNATURE E. C. H. Schmidt		22b. DATE SIGNED 29 May 1961	
22c. PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF MAY 31, 1961	
23c. NAME OF CEMETERY OR CREMATORY POTNAM CEMETERY		23d. LOCATION (City, town, or county) (State) GREENWICH, CONN.	
24. FUNERAL DIRECTOR'S SIGNATURE S. Hamilton Harrison		25a. REC'D BY REGISTRAR St. Michaels	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE JUN 1 '61	

(M)

6040

CERTIFICATE OF BEAR

WHEATLAND STATE DEPARTMENT OF HEALTH
BUREAU OF HEALTH AND HIGIENE
DIVISION OF PUBLIC HEALTH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE FACTS OF THE CASE.
Name of Patient: *John Doe*
Age: *35* Sex: *M*
Address: *123 Main St, Anytown, U.S.A.*
Date of Birth: *Jan 1, 1900*
Date of Admission: *Jan 15, 1940*
Diagnosis: *Acute Appendicitis*
Operation: *Appendectomy*
Date of Discharge: *Jan 20, 1940*
Physician: *Dr. J. B. Jones*
Hospital: *St. Mary's Hospital*
City: *Anytown* State: *Wheatland*

MARYLAND STATE DEPARTMENT OF HEALTH
TITIAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cordova</u>			c. LENGTH OF STAY IN 1b <u>Entire Life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			<u>X</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>IRA -</u> First <u>H</u> Middle Last <u>Secrist</u>						4. DATE OF DEATH <u>May</u> Month <u>1</u> Day Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 22, 1884</u>		9. AGE in years last birthday <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mainland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Calhoun Secrist</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Ann Wise</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Glen Secrist</u>			Address <u>Cordova Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Louis Meely</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>5-1-61</u>			
EXAMINER'S NAME (Type) <u>INE LTV</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>		22d. LOCATION (city, town, or county) (State) <u>Easton Md</u>					
23. FUNERAL DIRECTOR <u>Marion E. Newman</u>						ADDRESS <u>Easton Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

THE STATE
NEW YORK

(M)

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DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

6082

CERTIFICATE OF DEATH

Reg. Dist. No.

06070

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>		c. LENGTH OF STAY IN 1b <u>1 yr., 3 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Grim Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE SEMONE</u>		4. DATE OF DEATH Month Day Year <u>May 9, 19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>newspaper distributor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jacob Semone</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Carson Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-16-8172</u>	
17. INFORMANT <u>Mrs. C. H. Fick</u>		Address <u>910 Jefferson St., Wilmington, De</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u> DUE TO <u>2 yrs</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-8-</u> , 19 <u>58</u> , to <u>5-9-</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5-8-</u> , 19 <u>61</u> , and that death occurred at <u>4 a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Dr. P. Evans Cox</u> <u>Easton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 11, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oxford, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam & Son</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6083

CERTIFICATE OF DEATH

06071

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Talbot		MARYLAND		STATE Maryland		COUNTY Talbot	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN rural - St. Michaels		LENGTH OF STAY (in this place) 2 wks.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN St. Michaels			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rio Vista Nursing Home				STREET ADDRESS (If rural give location) Talbot			
3. NAME OF DECEASED (First) (Middle) (Last) NETTIE K. SHARP				4. DATE OF DEATH (Month) (Day) (Year) May 25, 1961			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Sept 9, 1874	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Oakland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Kepler				14. MOTHER'S MAIDEN NAME Jennie Lambert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT & ADDRESS Mrs. Virginia S. Shinn, St. Michael			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) Myocardial failure						3 yrs.	
ANTECEDENT CAUSE(S) DUE TO (B) atherosclerotic C.V.D.						-	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) uremia						-	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						-	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-23, 1952, to 5-25, 1961, that I last saw the deceased alive on 5-25, 1961, and that death occurred at 12:30 PM, from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city, town, state) St. Michaels, Md		DATE SIGNED 5-26-61	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 29, 1961		NAME OF CEMETERY OR CREMATORY Olivet Cemetery		LOCATION (City, town, or county) (State) St. Michaels, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS St. Michaels, Md	
DATE JUN 1 '61							

CERTIFICATE OF DEATH

1900

Form No. 1

1. Usual Residence of Deceased

John J. Taylor

MARYLAND

John J.

St. John's

Funeral - St. Michael's Church

John J.

His Wife Mary Ann

John J.

John J.

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SMOOTHWATER

ALL INFORMATION ON THIS CARD IS TO BE USED FOR THE PURPOSE OF IDENTIFYING THE DECEASED AND FOR THE PURPOSE OF RECORDING THE DEATH. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THE INFORMATION ON THIS CARD IS CORRECT AND COMPLETE. IF THE REGISTRAR FINDS THAT THE INFORMATION IS INCORRECT OR INCOMPLETE, HE SHALL RETURN THE CARD TO THE PERSON WHO FURNISHED IT, WITH A STATEMENT OF THE REASON THEREFOR. IF THE REGISTRAR FINDS THAT THE INFORMATION IS CORRECT AND COMPLETE, HE SHALL SIGN AND DATE THE CARD, AND RETURN IT TO THE PERSON WHO FURNISHED IT. IF THE REGISTRAR FINDS THAT THE INFORMATION IS INCORRECT OR INCOMPLETE, HE SHALL RETURN THE CARD TO THE PERSON WHO FURNISHED IT, WITH A STATEMENT OF THE REASON THEREFOR. IF THE REGISTRAR FINDS THAT THE INFORMATION IS CORRECT AND COMPLETE, HE SHALL SIGN AND DATE THE CARD, AND RETURN IT TO THE PERSON WHO FURNISHED IT.

John J.

John J.

John J.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6084

Item 7 film 0287 5/15/61

06072

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN 1b 46 hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg d. STREET ADDRESS 05 x 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katie Middle Simms Last Simms		4. DATE OF DEATH Month MAY Day 2 Year 1961	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 15, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Factory	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Neal		14. MOTHER'S MAIDEN NAME Lucy Neal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 220-05-1858A	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of heart DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 yr. 9 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1959 to 2 May 1961 , that (I) (we) last saw the deceased alive on 1 May 1961 , and that death occurred at 6:35 A.M., from the causes and on the date stated above.			
22a. SIGNATURE H. R. Trapnell		22b. DATE SIGNED 5-4-61	
22c. PHYSICIAN'S NAME (Type) H. R. Trapnell		22d. ADDRESS Federalsburg Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial MAY 6, 1961		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Federalsburg Cen.		23d. LOCATION (City, town, or county) (State) Federalsburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Trampton Son		25a. REC'D BY REGISTRAR MAY 9 '61	
ADDRESS Federalsburg Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

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I hereby certify that on the _____ day of _____ 1893
at _____ in the County of _____ State of _____
I was present at the marriage of _____
and _____
who were by me declared to be lawfully married.

Witness my hand and the seal of the said County at _____
this _____ day of _____ 1893.

County Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

6085
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06073

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 17 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		d. STREET ADDRESS Stevensville	
3. NAME OF DECEASED (Type or print) DR. Charles E. Snyder		4. DATE OF DEATH 5 - 11 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 23 - 1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY General Practitioner	
11. BIRTHPLACE (State or foreign country) Centerville Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles O Snyder		14. MOTHER'S MAIDEN NAME Sarah Ann Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-1940	
17. INFORMANT Mrs Margaret Snyder Stevensville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 metastasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture - femur		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 19, 1950 to 5/11 1961 , that (I) (we) lost saw the deceased alive on 2/11 1961 , and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 5/13/61	
22c. PHYSICIAN'S NAME (Type) Doctor P. E. Cox		22d. ADDRESS M. D. Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 15 - 1961	
23c. NAME OF CEMETERY OR CREMATORY Chesapeake		23d. LOCATION (City, town, or county) (State) Centerville Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James H. Butler Jr. Butler Bros. Centerville, Md.		25a. REC'D BY REGISTRAR DATE MAY 15 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

1922

(M)

PARROT

Female 77 days

Travis County, Tex.

Dr. C. A. ...

Walt H. ...

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

6086

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06074

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Susan</i> Middle <i>Benson</i> Last <i>Valliant</i>		4. DATE OF DEATH Month <i>MAY</i> Day <i>20</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 4, 1866</i>
9. AGE (In years last birthday) <i>95</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Thomas Parsons</i>		14. MOTHER'S MAIDEN NAME <i>Susan Ann Benson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i> (If yes, give war or dates of service) <i></i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mrs. Louise Willis</i> Address <i>Easton Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Arteriosclerosis, generalized</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i></i> (c) DUE TO <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i></i> INTERVAL BETWEEN ONSET AND DEATH <i>?</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1950</i> to <i>5-20/1961</i> , that (I) (we) last saw the deceased alive on <i>5/20/1961</i> , and that death occurred at <i>10:40 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>P. E. Cox</i>		22b. PHYSICIAN'S NAME (Type) <i>P. E. Cox</i> M. D. <i>Easton, Maryland</i>	
22c. DATE THEREOF <i>May 24, 1961</i>		22d. ADDRESS <i>Easton, Maryland</i>	
23a. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cem.</i>		23b. LOCATION (City, town, or county) <i>Easton Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Neuham + Son</i>		25a. REC'D BY REGISTRAR <i>MAY 25 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

6086

(M)

FILE

[Faint, mostly illegible text throughout the body of the document, possibly representing a letter or report.]

(J)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

6087

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 11 from birth certif. 5/10/61 iwk

06075

1. PLACE OF DEATH a. COUNTY <i>Jallot</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> c. LENGTH OF STAY IN 1b <i>18 min</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Delaware</i> b. COUNTY <i>46X-3</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seaford (Delaware, Md.)</i> d. STREET ADDRESS <i>Rt. #2 Box 261</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Baby</i> Middle <i>Boy</i> Last <i>Washington (A)</i>		4. DATE OF DEATH Month <i>5</i> Day <i>4</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 4, 1961</i>
9. AGE (In years last birthday) yrs. <i>18</i>		10. IF UNDER 1 YEAR Months <i>18</i> Days <i>min</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Easton, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert E. Washington</i>		14. MOTHER'S MAIDEN NAME <i>Mary Batson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>"Mother" Mary Washington</i>		Address <i>RFD #3 Box 261 Seaford, Dela.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prenatality 1st 113</i> DUE TO (b) <i>Twin</i> DUE TO (c) <i>lying cause last.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5-4</i> 19 <i>61</i> , to <i>5-4</i> 19 <i>61</i> , that (we) last saw the deceased alive on <i>5-4</i> 19 <i>61</i> , and that death occurred at <i>5:05 P.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>John E Baybutt</i>		22b. DATE SIGNED <i>5-6-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>John E. Baybutt</i>		22d. ADDRESS <i>M.D. Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Incineration 7/8/61</i>		23b. DATE THEREOF <i>7/8/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Hospital Easton, Md.</i>		23d. LOCATION (City, town, or county) (State) <i>7/8/61</i>	
24. FUNERAL DIRECTOR'S SIGNATURE		25. REC'D BY REGISTRAR DATE <i>MAY 10 '61</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

21P03P9X40

M

1

RECORD IN
CORRELATION
COLUMBIA UNIVERSITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6088

06076

Item 11 from Birth Certificate 5/10/61 ink

1. PLACE OF DEATH o. COUNTY <u>TA/lot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>2 hrs 17 min</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Seaford (Delaware, Md.)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>Washington</u> Last <u>(B)</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1961</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Easton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert E. Washington</u>		14. MOTHER'S MAIDEN NAME <u>Mary Baston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>R.F.D. #3 Box 261</u> <u>"Mother" Mary Washington Seaford, Dela.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity 2423</u> DUE TO (b) <u>Twin</u> DUE TO (c) <u>lying cause lost.</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-4 1961</u> to <u>5-4 1961</u> , that (we) last saw the deceased alive on <u>5-4 1961</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John E. Baybutt M.D.</u>		22b. DATE SIGNED <u>5-6-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John E. Baybutt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>incineration</u>		23b. DATE THEREOF <u>5/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>		23d. LOCATION (City, town, or county) (State) <u>Easton, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Memorial Hospital</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 10 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

1088

(M)

(S)

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

60889
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06077

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Annes</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u> d. STREET ADDRESS <u>"Wye Ferry"</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u>		First <u>Graham</u> Middle <u>Watson</u> Last <u>Watson</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-98</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing & Heating</u>		11. BIRTHPLACE (State or foreign country) <u>Centerville Maryland</u>			
13. FATHER'S NAME <u>Graham Watson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Keating</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW #1+2</u>		16. SOCIAL SECURITY NO. <u>WW #1+2</u>		17. INFORMANT <u>John G. Watson Jr.</u> Address <u>7700 Magnolia Drive Seaside Delaware</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>23</u> <u>am</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Louis Merty</u>		M.D. <u>WELTK</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-29-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>May 30, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Schenck Cemetery Co</u>			
22d. LOCATION (City, town, or country) <u>Wilmington Delaware</u>		(State)		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
23. FUNERAL DIRECTOR <u>Wm. R. Patton, Patton Bros</u>		ADDRESS <u>Centerville Maryland</u>		DATE <u>JUN 2 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6090 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 60178

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL QUEEN ANNE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL QUEEN ANNE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle LOLLAR Last WHITBY		4. DATE OF DEATH Month MAY Day 17 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 5, 1893
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former owner		10b. KIND OF BUSINESS OR INDUSTRY farming	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NOAH WHITBY		14. MOTHER'S MAIDEN NAME MARGARET MORRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Harry L. Whitby Queen Anne, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary artery occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery arteriosclerosis 10 year DUE TO Generalised arteriosclerosis (c) chronic		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959 to May 1961 , that I last saw the deceased alive on May 15, 1961 , and that death occurred at 8 P.M. from the causes on and on the date stated above.			
ACTUAL SIGNATURE Kurt Lederer M.D.		ADDRESS (Street, city or town, state) QUEEN ANNE DATE SIGNED 7/8	
PHYSICIAN'S NAME (Type) KURT LEDERER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 20, 1961	
22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Hillsboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Moorhead ADDRESS Denton, Md.		24a. REC'D BY REGISTRAR DATE MAY 23 '61	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

<p>Place of death</p> <p>1. Home</p> <p>2. Hospital</p> <p>3. Prison</p> <p>4. Other</p>		<p>Age at death</p> <p>5. Years</p> <p>6. Months</p> <p>7. Days</p>	
<p>Sex</p> <p>8. Male</p> <p>9. Female</p>		<p>Color</p> <p>10. White</p> <p>11. Black</p> <p>12. Other</p>	
<p>Marital status</p> <p>13. Single</p> <p>14. Married</p> <p>15. Widowed</p> <p>16. Divorced</p>		<p>Occupation</p> <p>17. None</p> <p>18. Other</p>	
<p>Place of birth</p> <p>19. State</p> <p>20. Country</p>		<p>Place of residence</p> <p>21. State</p> <p>22. County</p> <p>23. City</p>	
<p>Cause of death</p> <p>24. Disease</p> <p>25. Injury</p> <p>26. Poison</p> <p>27. Other</p>		<p>Immediate cause</p> <p>28. Disease</p> <p>29. Injury</p> <p>30. Poison</p> <p>31. Other</p>	
<p>Underlying cause</p> <p>32. Disease</p> <p>33. Injury</p> <p>34. Poison</p> <p>35. Other</p>		<p>Contributing cause</p> <p>36. Disease</p> <p>37. Injury</p> <p>38. Poison</p> <p>39. Other</p>	
<p>Period of illness</p> <p>40. Days</p> <p>41. Weeks</p> <p>42. Months</p> <p>43. Years</p>		<p>Time of death</p> <p>44. Hour</p> <p>45. Minute</p> <p>46. Second</p>	
<p>Signature of physician</p> <p>47. Name</p> <p>48. Address</p>		<p>Signature of registrar</p> <p>49. Name</p> <p>50. Address</p>	
<p>Signature of informant</p> <p>51. Name</p> <p>52. Address</p>		<p>Signature of witness</p> <p>53. Name</p> <p>54. Address</p>	
<p>Signature of funeral director</p> <p>55. Name</p> <p>56. Address</p>		<p>Signature of coroner</p> <p>57. Name</p> <p>58. Address</p>	
<p>Signature of health officer</p> <p>59. Name</p> <p>60. Address</p>		<p>Signature of registrar</p> <p>61. Name</p> <p>62. Address</p>	

ALL INFORMATION IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, UNTIL THE 10TH DAY OF JANUARY, 1918, WHEN IT SHALL BE FORWARDED TO THE NATIONAL BUREAU OF VITAL STATISTICS, WASHINGTON, D. C.

CERTIFICATE OF DEATH

Reg. Dist. No. 66079

6091

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Talbot		MARYLAND		STATE Maryland		COUNTY Talbot	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - St. Michaels		LENGTH OF STAY (in this place) 5 wks		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rio Vista Nursing Home				STREET ADDRESS (If rural give location) Talbot			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MARY E. WILTBANK				4. DATE OF DEATH (Month) (Day) (Year) May 25, 1961			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 8, 1885	9. AGE last birthday 76 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) St. Michaels, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Townsend				14. MOTHER'S MAIDEN NAME Annie M. Porter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 66-4444		17. INFORMANT & ADDRESS 874 Gilmer Ave., John T. Wiltbank, Norfolk 2, Va.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) cerebral thrombosis				INTERVAL BETWEEN ONSET AND DEATH 7 days			
ANTECEDENT CAUSE(S) DUE TO (B) atherosclerotic cardiac and cerebro							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) vas. d.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. chronic cardiac failure							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-11 , 19 53 , to 5-25 , 19 61 , that I last saw the deceased alive on 5-25 , 19 61 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
SIGNATURE Wm. M. Tucker				ADDRESS (Street, city, town, state) St. Michaels, Md.			
DATE May 27, 1961				DATE SIGNED 5-26-61			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 27, 1961		NAME OF CEMETERY OR CREMATORY Olivet Cemetery		LOCATION (City, town, or county) (State) St. Michaels, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE William S. K...		25. FUNERAL DIRECTOR'S SIGNATURE L. Hampton Harrison			
DATE JUN 1 '61				ADDRESS St. Michaels			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-45 10M

CERTIFICATE OF DEATH

Form No. 100

1. Name of Deceased John T. Johnson		2. Date of Death May 27, 1931	
3. Place of Death St. Michaels, Md.		4. Age 76	
5. Sex Male		6. Race White	
7. Occupation Farmer		8. Cause of Death Heart Disease	
9. Physician Dr. J. W. Johnson		10. Burial Place St. Michaels, Md.	
11. Signature of Physician J. W. Johnson		12. Signature of Registrar J. W. Johnson	
13. Date of Report May 27, 1931		14. Place of Report St. Michaels, Md.	

RECEIVED
MAY 27 1931
BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6092

Items 3, 8 & 9 fill in 6/6/61 ink

06080

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 1 hr. 20 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georgesville d. STREET ADDRESS 17X-2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr J Lawrence First James Middle Lawrence Last Wood, Sr.		4. DATE OF DEATH Month May Day 26 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 20, 1900
9. AGE (In years last birthday) 61 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY farm owner	
11. BIRTHPLACE (State or foreign country) Caroline Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J Fred Wood		14. MOTHER'S MAIDEN NAME Sella Callahan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-36-1069	
17. INFORMANT J Lawrence Wood Jr - Centerville, Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Multifactorial fibrillation due to coronary atherosclerosis & old myocardial infarction DUE TO (b) any DUE TO (c) any PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1960 to 26 May 1961 , that (I) (we) last saw the deceased alive on 26 May 1961 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Thurston Harrison		22b. DATE 29 May 61	
22c. PHYSICIAN'S NAME (Type) THURSTON HARRISON		22d. ADDRESS Centerville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 30 61	
23c. NAME OF CEMETERY OR CREMATORY Chesterfield		23d. LOCATION (City, town, or county) (State) Centerville Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James H. Burton Jr. of Burton Bros. Centerville, Md.		25a. REC'D BY REGISTRAR June 2 '61	
25b. REGISTRAR'S SIGNATURE William S. Harris			

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BP 1

(M)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

(I)

Signature of Registrar

Signature of Deceased

Signature of Next of Kin

1

6093

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06081

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>CAROLINE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Readin</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DENTON</i>	
c. LENGTH OF STAY IN 1b <i>15 hrs - 10 min</i>		d. STREET ADDRESS <i>05X-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Ralph HERMAN Wothers</i>		4. DATE OF DEATH Month Day Year <i>5 9 1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 1, 1913</i>
9. AGE (In years last birthday) <i>47</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Furniture</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JOHN H. WOOTERS</i>		14. MOTHER'S MAIDEN NAME <i>JENNIE SMITH</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JAMES WOOTERS HILLSBORO MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Myocardial Infarction</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>16 hours</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8-May, 1961</i> to <i>9-May, 1961</i> that (I) (we) last saw the deceased alive on <i>9-May, 1961</i> , and that death occurred at <i>2:30 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Dale R. Kollman</i>		22b. ADDRESS <i>16 N. 2nd St. Denton, Md</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dale R. Kollman</i>		22d. ADDRESS <i>16 N. 2nd St. Denton, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>MAY 12, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>DENTON</i>		23d. LOCATION (City, town, or county) (State) <i>DENTON, MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Edgar Moore & Son</i>		25. REC'D BY REGISTRAR <i>Denton Md</i>	
25a. DATE <i>MAY 18 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

5/10/61 DATE SIGNED

100-100000

CERTIFICATE OF DEATH

100-100000

(M)

100-100000

100-100000

100-100000

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100-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
6094
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06082

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Easton c. LENGTH OF STAY IN 1b 1 year d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oaklands		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Easton d. STREET ADDRESS Oaklands e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle M. Last WYATT		4. DATE OF DEATH Month May Day 24 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1874
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min. 0	11. IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert Plummer		14. MOTHER'S MAIDEN NAME Elizabeth Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Orville Wyatt	
17. INFORMANT "Oaklands"		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis heart disease 420.0 DUE TO Paroxysmal Atrial Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 24 hr. DUE TO None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-19-1961 to 5-24-1961 , that (I) (we) last saw the deceased alive on 5-24-1961 , and that death occurred at 7:00 PM from the causes and on the date stated above.			
22a. SIGNATURE William S. Winters		22b. DATE SIGNED 4/25/61	
22c. PHYSICIAN'S NAME (Type) Dr. William S. Winters		22d. ADDRESS Easton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 26, 1961	
23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City, town, or county) (State) Easton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		25a. REC'D BY REGISTRAR MAY 29 '61	
ADDRESS Easton, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

6090

11

1

CONFIDENTIAL

10-10-60

10-10-60

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